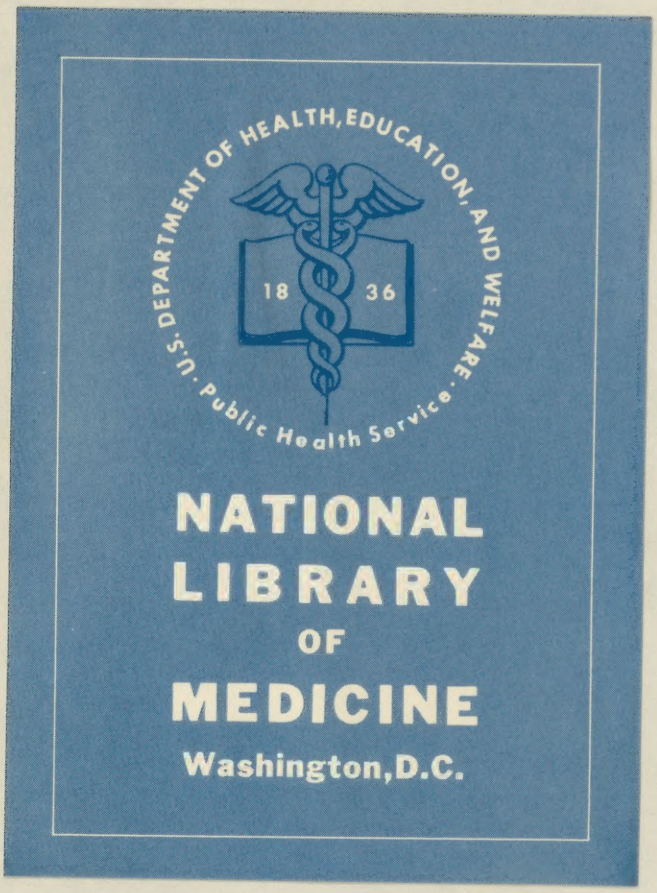

CARE OF THE CHRONICALLY ILL BETWEEN HOSPITAL AND HOME

New York State Commission to Formulate a Long Range Health Program

also known as

New York State Health Preparedness Commission

1946

CARE OF THE CHRONICALLY ILL BETWEEN HOSPITAL AND HOME,

A summary of some of the problems in providing adequate care for the chronically ill "between hospital and home" and suggestions for their solution. In addition to new material, this discussion, to some extent, is a consolidation of publications previously distributed by the Commission which have dealt with the different types of facilities and services needed in a comprehensive program for the care of the chronically ill.

New York State Commission to Formulate a Long Range Health Program
also known as
New York (State) Health Preparedness Commission,
1946

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CARE OF THE CHRONICALLY ILL BETWEEN HOSPITAL AND HOME

Introduction

The chronically ill can be cared for at home, in the hospital or in institutions intermediate between hospital and home, the place of care selected depending largely upon the medical needs of the patient at the time. Whenever possible and medically expedient, an ill person should be cared for at home in the environment with which he is familiar and where he is more likely to be content. However, many of the chronically ill, although they do not require treatment in a hospital, do not have homes which can care for them properly. These must depend upon "between hospital and home" facilities -- substitute homes such as convalescent or nursing homes, "sanatoria," county or city public homes, voluntary homes for the aged and supervised boarding homes.

Although the following presentation is devoted to a discussion of this intermediate type of care, it should be kept in mind that this is but one of several kinds of care needed by the chronically ill. They must be transferred from one variety of care to another, as their changing conditions demand. Therefore, a lack of proper between hospital and home facilities will create a "bottleneck" in making effective any comprehensive plan for the care of the chronically ill. For example, without such facilities many patients will be retained in general hospitals who might otherwise be discharged, thus depriving another patient of the opportunity of profiting from the hospital care which he needs. Similarly, a patient who cannot be cared for at home, yet who does not actually need the intensive medical service of a general hospital, may have to be hospitalized at relatively higher cost for want of more appropriate facilities.

The subsequent presentation is devoted to various existing facilities having potentialities for providing between hospital and home care of good quality. However, it is important to remember that they are not necessarily the only means

of solution; for, as time goes on, it is quite possible that it will be found expedient to develop wings of general hospitals for this purpose, in addition to the between hospital and home facilities as we know them today.

The Problem

Whenever possible, and compatible with his medical needs, an ill person should be cared for at home. Many of the chronically ill may be partially or wholly ambulatory, may not require institutional or bedside care, may be self-directing and capable of remaining in their own homes, yet may need a sheltered, carefully planned mode of living. This would include continued medical supervision to maintain the highest level of physical performance possible for the patient, within the limitations imposed by the disease or disability. Approximately 85 per cent of the chronically ill probably can be cared for in their own homes. However, many patients cannot receive adequate care at home -- those who need hospitalization or other institutional care and others who, not requiring institutional care, do not have homes capable of providing proper care. These are the responsibility of "between hospital and home" facilities -- substitute homes such as convalescent or nursing homes, "sanatoria," county or city public homes and their infirmaries, voluntary homes for the aged, small proprietary hospitals and supervised boarding homes.

"Between hospital and home" facilities are neither purely medical nor social, but medical-social in character. Because they fall between these two fields of service they have not received the attention they deserve. Yet they are vital factors in providing care for the chronically ill and, in recent years, their numbers and aggregate capacities have increased greatly. It is, therefore, timely and in the public interest to examine more closely their present status, their potentialities and the methods by which they might be improved and encouraged to become a better integrated and more valuable part of the total gamut of medical facilities and services.

There are many reasons for their emergence: the growing demand for medical and medical domiciliary care; the general lack of preventive education in the geriatric field; the increasing proportion of the aged in the general population; the decreasing sense of responsibility of relatives in caring for their kin; and the tendency of families, especially those in urban areas, to reside in compact living quarters. These factors, among others, have created the demand for medical, nursing and custodial services outside the patient's own home.

PROVIDING QUALITY CARE

Eventually we must estimate the extent and specific kind of care needed for the adequate care of the chronically ill; ascertain the existing resources available; suggest means by which current facilities and services can be expanded; modified and adapted to meet the demand; and determine the additional facilities and services required. As a first step, and since many of the chronically ill require "between hospital and home" facilities, the discussion which follows deals with institutions which, on the whole, are potentially capable of providing this much needed service.

In this connection, it should be emphasized that the chronically ill are from all economic strata and that the facilities and services in New York State are today inadequate in both volume and quality to meet the needs of most persons able to pay for their care. Furthermore, tomorrow's counterpart of today's aged, chronically ill, medically indigent patients will be individuals who, at age 65, will be collecting Old Age and Survivor's Insurance benefits paid for during a lifetime of work and payroll deductions, and who also are likely to be carrying hospitalization insurance. They will not have exhausted their savings, held in trust by government, in paying for a prolonged period of active medical service. Though these will be only one group among the chronically ill, and although their benefits

may be limited, they will be able to pay modest charges in full, or somewhat higher fees in part. This aspect of our Social Security Law was established on the philosophy that it would preserve a sense of independence in old age. The development of proper facilities and services for such citizens, therefore, would fulfill the obligation of making that independence a reality.

Sources of Information

The subsequent discussion is limited to nursing and convalescent homes, supervised boarding homes, public homes and voluntary homes for the aged, information being available on these facilities. These are frequently used for the placement of public charges[1/] and, as a group, care for the majority of those ill persons regarded as needing institutional care but not hospitalization.

In addition to the more general references cited, the factual data, concepts and conclusions presented specifically relative to New York State are primarily based on a synthesis of (1) studies made by the Health Preparedness Commission; (2) material previously prepared and distributed by the Commission to individuals assisting in planning for the care of the chronically ill; and (3) conferences of the Commission staff with informed local individuals. The method and extent of coverage of local areas of New York State is shown in Figure #1, page 6, and Table 1, pages 7 and 8. Much of the supporting material is included in the following list:

1/ "Public charge" includes all persons whose care is provided wholly or partially at public expense.

I. Studies made and officially published by the Health Preparedness Commission. 2/

1. Health and Medical Care, Niagara County, New York, 1944.

2. Health and Medical Care, Ontario County, New York, 1944.

3. Health and Medical Care, Seneca County, New York, 1944.

4. Health and Medical Care, Washington County, New York, 1944.

II. Material prepared by the Commission, mimeographed and distributed to individuals assisting in planning for the care of the chronically ill.

5. Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill, (in cooperation with the New York State Association of Public Welfare Officials), 1945.

6. A Study of Nursing Homes in New York State, 1943, May 1946.

7. Regulation of Nursing Homes in New York State, September 1946.

8. Licensure of Nursing Homes in Other States, September 1946.

9. Official Planning for the Care of the Chronically Ill in Other States, May 1946.

III. Conferences of the Commission staff with informed local individuals.

10. The Commission staff interviewed approximately 87 public welfare and public health officials, responsible practitioners and persons engaged in community planning in 15 counties and 11 cities in upstate New York. (September and October 1945). See Figure 1, page 6, and Table 1, pages 7 and 8.

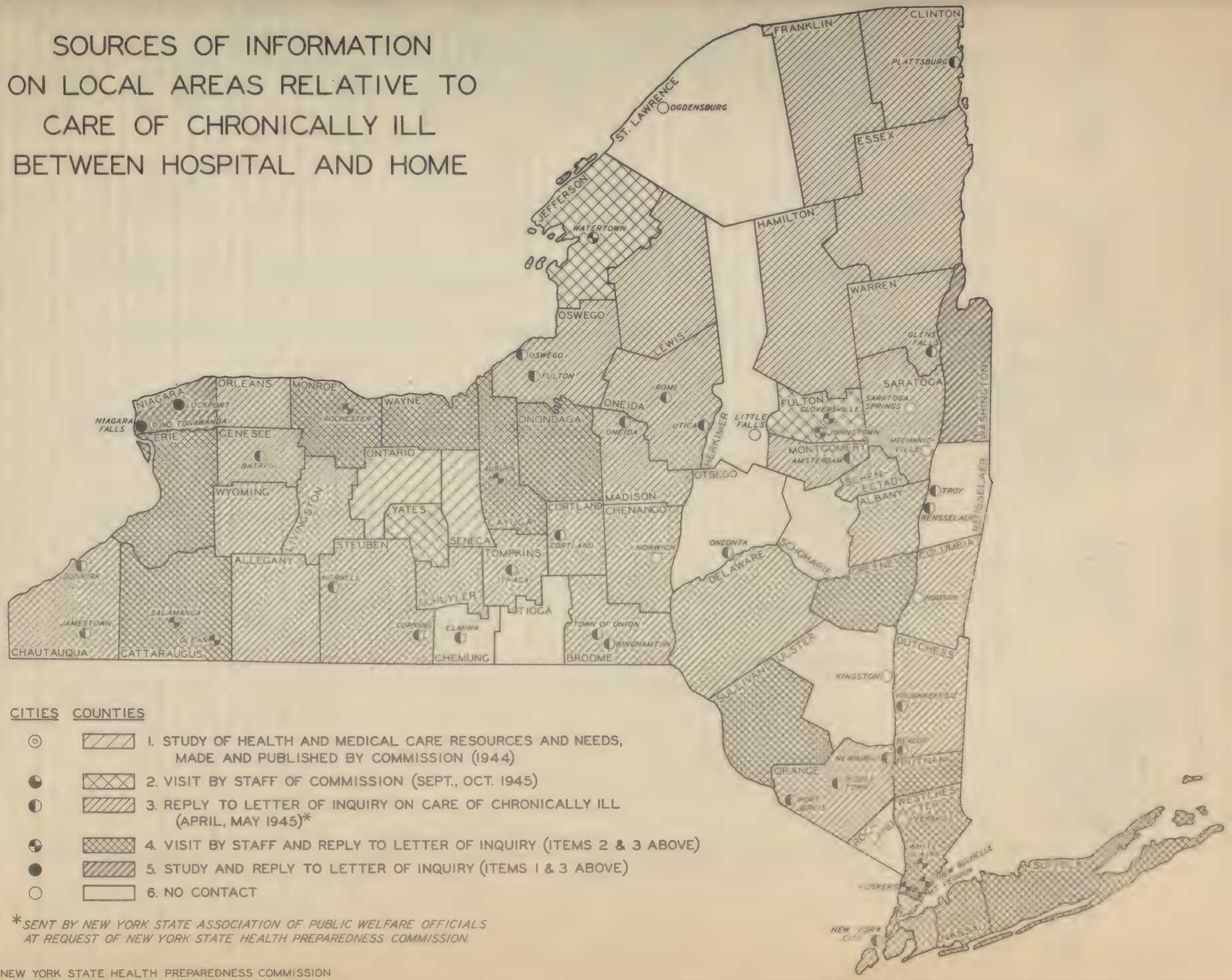
IV. Other sources of information.

11. Statistical data on nursing homes certified by local departments of public welfare, as of July 1945, which were made available by the New York State Department of Social Welfare.

12. New York State Temporary Legislative Commission to Formulate a Long Range State Health Program (New York State Health Preparedness Commission), Medical Care in New York State, 1939, Legislative Document (1940) No. 91, 1940.

2/ Printed individually and subsequently reprinted in the 1943-1944 Report of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program (New York State Health Preparedness Commission), Legislative Document (1944) No. 56A, 1945.

SOURCES OF INFORMATION ON LOCAL AREAS RELATIVE TO CARE OF CHRONICALLY ILL BETWEEN HOSPITAL AND HOME



CITIES COUNTIES

- ◎ ▨ 1. STUDY OF HEALTH AND MEDICAL CARE RESOURCES AND NEEDS, MADE AND PUBLISHED BY COMMISSION (1944)
- ◕ ▩ 2. VISIT BY STAFF OF COMMISSION (SEPT., OCT. 1945)
- ◐ ▨ 3. REPLY TO LETTER OF INQUIRY ON CARE OF CHRONICALLY ILL (APRIL, MAY 1945)*
- ◕ ▩ 4. VISIT BY STAFF AND REPLY TO LETTER OF INQUIRY (ITEMS 2 & 3 ABOVE)
- ● ▨ 5. STUDY AND REPLY TO LETTER OF INQUIRY (ITEMS 1 & 3 ABOVE)
- ○ □ 6. NO CONTACT

*SENT BY NEW YORK STATE ASSOCIATION OF PUBLIC WELFARE OFFICIALS AT REQUEST OF NEW YORK STATE HEALTH PREPAREDNESS COMMISSION.

NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

Figure 1

Table 1. Sources of Information on Local Areas Relative to the Care of the Chronically Ill.

Welfare District	Information Obtained	Source of Information			No Information Obtained
		Reply to Written Inquiry Sent Local Commissioner of Public Welfare Relative to Care of the Chronically Ill (April 1945)	Interviews of Commission Staff with Representative Local Personnel (Sept.,Oct.1945)	Study Made and Published by Health Preparedness Commission on Local Health & Medical Care, Resources & Needs (1944)	
Total 1/	89	83	26	7	17
County districts	48	43	15	4	9
City districts	41	40	11	3	8
Albany Co.	x	x			
Allegany Co.	x	x			
Broome Co.	x	x			
Binghamton	x	x			
Union (town)	x	x			
Cattaraugus Co.	x	x	x		
Olean	x	x	x		
Salamanca	x	x	x		
Cayuga Co.	x	x	x		
Auburn	x	x	x		
Chautauqua Co.	x	x			
Dunkirk	x	x			
Jamestown	x	x			
Chemung Co.					x
Elmira	x	x			
Chenango Co.	x	x			
Norwich					x
Clinton Co.	x	x			
Plattsburgh	x	x			
Columbia Co.	x	x			
Hudson					x
Cortland Co.	x	x			
Cortland	x	x			
Delaware Co.	x	x			
Dutchess Co.	x	x			
Beacon	x	x			
Poughkeepsie	x	x			
Erie Co.	x	x	x		
Essex Co.	x	x			
Franklin Co.	x	x			
Fulton Co.	x		x		
Gloversville	x	x	x		
Johnstown	x	x	x		
Genesee Co.	x	x			
Batavia	x	x			
Greene Co.	x	x	x		
Hamilton Co.	x	x			
Herkimer Co.					x
Little Falls					x
Jefferson Co.	x		x		
Watertown	x	x	x		
Lewis Co.	x	x			
Livingston Co.	x	x			
Madison Co.	x	x			
Oneida	x	x			
Monroe Co.	x	x	x		
Rochester	x	x	x		
Montgomery Co.	x	x			
Amsterdam	x	x			

1/ During 1945 there were 106 local welfare districts, 57 county and 49 city districts.

(Concluded on following page)

Table 1. Sources of Information on Local Areas Relative to the Care of the Chronically Ill. (concl.)

Welfare District	Information Obtained	Source of Information			No Information Obtained
		Reply to Written Inquiry Sent Local Commissioner of Public Welfare Relative to Care of the Chronically Ill (April 1945)	Interviews of Commission Staff with Representative Local Personnel (Sept.,Oct.1945)	Study Made and Published by Health Preparedness Commission on Local Health & Medical Care, Resources & Needs (1944)	
Nassau Co.	x	x	x		
Niagara Co.	x	x		x	
Lockport	x	x		x	
Niagara Falls	x	x		x	
North Tonawanda	x			x	
Oneida Co.	x	x			
Rome	x	x			
Utica	x	x			
Onondaga Co.	x	x	x		
Ontario Co.	x			x	
Orange Co.	x	x			
Middletown	x	x			
Newburgh	x	x			
Port Jervis	x	x			
Orleans Co.	x	x			
Oswego Co.	x	x			
Fulton	x	x			
Oswego	x	x			
Otsego Co.					x
Oneonta	x	x			
Putnam Co.	x	x	x		
Rensselaer Co.					x
Rensselaer	x	x			
Troy	x	x			
Rockland Co.					x
St. Lawrence Co.					x
Ogdensburg					x
Saratoga Co.	x	x			
Mechanicville					x
Saratoga Springs					x
Schenectady Co.	x	x			
Schoharie Co.					x
Schuyler Co.	x	x			
Seneca Co.	x			x	
Steuben Co.	x	x			
Corning	x	x			
Hornell	x	x			
Suffolk Co.	x	x	x		
Sullivan Co.	x	x	x		
Tioga Co.					x
Tompkins Co.	x	x			
Ithaca	x	x			
Ulster Co.					x
Kingston					x
Warren Co.	x	x			
Glens Falls	x	x			
Washington Co.	x	x		x	
Wayne Co.	x	x	x		
Westchester Co.	x	x	x		
Mt. Vernon	x	x	x		
New Rochelle	x	x	x		
Peekskill					x
White Plains	x	x	x		
Yonkers	x	x	x		
Wyoming Co.	x	x			
Yates Co.	x		x		
New York City	x	x			

Convalescent Care

The active medical service required during an acute illness or an acute exacerbation of a chronic illness is usually provided either in the patient's own home or in a hospital. As partial recovery or maximum immediate benefit from intensive medical care is obtained, consideration should be given to completing the patient's restoration to full health or, if this is not possible, to attaining the maximum arrest of the disease and preparing him for return to as useful a life as possible within the limitations of his handicap.

PURPOSE OF CONVALESCENCE

This is the convalescent stage, the period between the subsiding or arrest of a disease and as complete a restoration to health as is possible. Planning for it should begin while active treatment is still progressing and, whenever medically feasible and socially desirable, should include a regime for return to independent earning power through rehabilitative training. The convalescent period, although it may be protracted, is temporary, being terminated by the onset of either (a) full recovery or (b) partial recovery, or at least improvement over the status on admission. If neither full nor partial recovery or improvement seems likely, the patient is not a suitable candidate for convalescent care, but may require medical domiciliary care. The length of time needed for convalescence varies with specific disease entities, individual capacity for recuperation and the status of medical knowledge. The term "convalescence" in association with chronic illness is used deliberately for, even though most of the chronically ill may be incapable of achieving full recovery in a relatively brief period, many can improve somewhat over a longer period and some may be restored to full health with proper aids to convalescence. For example, the convalescent periods following a heart attack, rheumatic fever, thyroid surgery, a recurrent hernia, a fractured thigh, severe diabetes, ulcerative colitis and an amputation associated with diabetes are generally prolonged, yet often result in marked improvement and close approximation to normal health.

The Welfare Council of New York City has estimated that half of the patients discharged from convalescent homes in New York City in 1933 were suffering from a chronic disease.[3] Of 850 patients admitted in 1941 to one convalescent home[4], operated in close affiliation with a large, voluntary general hospital, at least 284 (one third) suffered from a chronic disease. The duration of stay of all patients ranged from 17 to 77 days, the average being 23 days. The stay of the chronic patients did not greatly exceed this average.

The criteria of admission for a patient with chronic disease to this convalescent home are three-fold: (1) he must be sufficiently ambulatory to permit walking to the bathroom and dining room, (2) he must be considered capable of some improvement in health and (3) he must be "actually ready for discharge from the hospital." The liberality of these admission requirements is evident from the fact that the patients admitted included some who needed intra-muscular injections or surgical dressings, patients with colostomies and post-operative patients with advanced cancer.

Admittedly, the prognoses of some of the chronically ill are poor, even verging on the need for terminal care. However, when there is reason to believe that there is a possibility of improvement, the chronically ill should be given an opportunity to respond to proper convalescent care of high quality before being classified as custodial cases, probably destined to spend their ensuing years as non-productive members of society. Anything less would seem defeatist, anti-social and, considered in the light of our aging population and productive manpower needs, uneconomical. This was emphasized by Mr. Lawrence Frank who, at the Conference on Convalescence and Rehabilitation sponsored by the New York

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3/ Mary C. Jarrett, Chronic Illness in New York City, Welfare Council of New York City, Columbia University Press, 1933. 2 vol.

4/ The Neustadter Home for Convalescents of Mt. Sinai Hospital, New York City. See Report of Subcommittee on Convalescence of the Committee on Chronic Illness, Welfare Council of New York City, October 1942. (Mimeographed).

Academy of Medicine, stated: "We are going to have more old people with more chronic illness, which is now coming earlier in life . . . . We are also becoming aware that neglected convalescence is one of the largest contributing factors to premature aging as well as to the fixation of chronic illness."[5/]

The need for and value of proper convalescence must be understood by the layman, who is at once the consumer, the philanthropic contributor and the taxpayer. It should be accepted and advocated more widely by practicing physicians and its place in total medical planning for the individual patient should receive greater emphasis in medical education. Physicians generally have given insufficient consideration to ascertaining the needs of patients following the period of intensive medical service, have not prescribed and supervised a clear cut regime of convalescence and have not concertedly insisted that the community provide proper facilities and services for this purpose. Had they done so, it is likely that well organized convalescent facilities and services would today be more available, relapses of patients less frequent, their re-admissions to hospitals less numerous and restoration to earning power more rapid and complete.

WHERE PROVIDED Whenever possible, convalescent care should be provided in the patient's own home, supplemented, if necessary, by such community resources as visiting nurse, housekeeper and rehabilitation training services. Yet a number of factors make it impossible for some homes properly to provide this care; the patient may be living alone with no one to care for him; the home may be physically inadequate or overcrowded; the family may be incapable of carrying out instructions; too specialized nursing care may be required; the adult members of the household may all be employed, leaving no one to care for the patient; or the patient himself may be a difficult personality more responsive to instructions from relative strangers than from his own family. Under such circumstances care may have to be provided in "between hospital and home" facilities.

5/ New York Academy of Medicine, Convalescence and Rehabilitation, New York, 1944, p. 142.

The possibility of providing convalescent care at home, even under difficult circumstances, and in specialized institutions is illustrated in the following cases:

> When an intelligent, adolescent boy, recovering from osteomyelitis involving both legs, was ready for hospital discharge late in the spring, his condition required frequent changes of dressings and daily exposure to the sun for specified periods. No convalescent home capable of changing the dressings was available. His parents, who lived in a slum district and spoke no English, had little understanding of American customs and no appreciation of the value of convalescent care. They were adamant against convalescent home placement. The attending physician, cognizant of the boy's intelligence and sense of responsibility, instructed the lad on the regime to be followed -- lying in the sun daily in bathing trunks on an accessible roof and returning to the hospital clinic periodically for a change of dressings and continued medical supervision. Convalescence progressed normally during the ensuing summer months, the boy attended school in the winter and, during the following summer, went to a specially selected camp, all the while seeing the physician periodically. Convalescence was uneventful and successful.

This indicates that, even when home conditions may be partially adverse, proper convalescence can be achieved when the physician clearly outlines the regime and the patient has the capacity to understand and carry out instructions.

> It was impossible to locate a nursing or convalescent home which would admit and change the dressings of a 36 year old, diabetic Negro woman following amputation of one leg above the knee. Therefore, upon discharge from the hospital, the patient returned to her own home, was taught by a visiting nurse to prepare her diet and give herself insulin and returned to the hospital clinic periodically for a change of dressings. The patient's morale was shattered, there was no incentive to live. This state of mind was due to her inability to simultaneously accommodate herself to a new handicap and assume numerous new responsibilities -- restrictions on food, preparation of a special diet, injection of insulin and limitations of locomotion caused by the amputation. In fact, pending healing of the limb, there was a question as to the advisability of buying an artificial leg and trying to teach the patient to use it. As soon as the need for dressings ended, the clinic physicians ordered the patient to a convalescent home in the country, a final attempt to restore morale. The patient was relieved of some responsibilities, the surroundings were pleasant and, even though insulin was still self-injected, the home prepared the diet and also showed the patient how she might more easily prepare it for herself in the future. Physical and mental recovery were rapid, the artificial leg was purchased and was soon being used adeptly by the patient.

This case shows the role of convalescent care in relieving a patient of some responsibilities, bolstering her morale and thus facilitating accommodation to physical and dietary limitations.

> A very elderly, white-haired Negro preacher had suffered a double amputation, one above and one below the knee. He was determined to walk again but the sympathetic hospital medical staff considered him far too old. Because of his helplessness he was sent to a convalescent home. However, the preacher's small and poor congregation, undismayed, raised funds for one artificial limb and money towards the second -- and then the hospital contributed the rest. Surprisingly, and despite his age, the patient did use the artificial limbs, his proudest moment being the first Sunday when he again stood behind the pulpit preaching to his loyal congregation.

This is an example of the contribution of character and sheer willpower to convalescence, while the following case illustrates an adaptation to medical domiciliary care.

> A progressively arthritic patient, now 45, was admitted to a nursing home as a young girl directly from college. Now almost helpless and never physically able to be discharged, although receiving adequate medical attention, the patient pays part of her care from earnings from a rather large greeting card business conducted by telephone.

Convalescent care, wherever provided, should include proper nutrition to overcome the ravages of disease, fresh air, sunshine, recreation and pleasant surroundings, combined with medical supervision and service, nursing care, occupational therapy and rehabilitative training, as required. These are the interdependent and interrelated nutritional, physical and psychological factors needed to restore physical and mental health and spiritual well-being and to prevent human atrophy, economic dependence and a "what's the use" state of mind.

MEDICALLY ECONOMICALLY AND SOCIALLY SOUND

Properly organized convalescence, wherever provided, is medically, economically and socially sound. This was demonstrated during the recent war by the rapidity with which our armed forces were able to return casualties to full combat duty or, for those to be discharged from service, to independent earning power. Among a group of atypical pneumonia cases the Army Air Forces found that, with unsupervised convalescence, 45 days hospitalization and a 30 per cent recurrence rate resulted, whereas, under a planned convalescent program, only 31 days hospitalization and a three per cent recurrence rate occurred.[6/] The community workshop in Boston,

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6/ Ibid., p. 83.

sponsored by the Liberty Mutual Life Insurance Company to provide vocational rehabilitative training to its convalescent compensation cases, has effected a net saving of benefits, reflecting a shortening of the convalescent period and restoration to independent earning power.[7] The study of Weiskotten, Jensen and Thomas has shown that intelligent medical follow-up of patients discharged from a hospital ward prevented relapses and the subsequent need for rehospitalization.[8]

Similarly, proper convalescent care conserves hospital resources and increases their effectiveness. When a close administrative relationship, including an interchange of records and opinions, exists between a hospital and a convalescent home of high quality, patients can readily be discharged from the former to the latter. In this way continuity of medical care is maintained and the benefits of costly hospital service are not reduced by indifferent after-care. Further, since such a working agreement assures the home of the hospital's backing and its willingness quickly to readmit a patient, when necessary, it is possible for the convalescent home to have a flexible and liberal admission policy.

STANDARDS OF CARE

Convalescent care, to be truly effective, must be of such quality as to offer the maximum opportunity to the patient for rehabilitation and return to a period of economic usefulness and happiness. On the other hand, it is not hospital care. The type of institutional facility which is considered necessary to furnish true convalescent care may be guaged from the following criteria formulated and published by the Subcommittee on Convalescence of the Committee on Chronic Illness, Welfare Council of New York City:[9]

7/ Ibid., p. 61.

8/ H. G. Weiskotten, Frode Jensen and Margaret A. Thomas, Medical Care of the Discharged Hospital Patient, New York, The Commonwealth Fund, 1944.

9/ Welfare Council of New York City, Op. Cit.

1. Location: preferably in the country and not more than one hour's travelling distance from an affiliated hospital.

2. Affiliation with a general hospital by means of:

   (a) having several members on the boards of both institutions;

   (b) direction of the convalescent home by a physician who is on the staff of the hospital;

   (c) interchange of medical records; and

   (d) a regular procedure for transfer of patients from the hospital to the home, or from the home to the hospital, if necessary.

3. Physical plant: Grounds ample for mild exercise and recreation. Separate wings for male and female patients with administrative, surgical, recreational and occupational therapy facilities in a part of the building connecting the two wings. Adequate toilet facilities, in the ratio of one toilet for every seven patients, with extra individual lavatories for colostomy patients, in each wing. Wards preferably not larger than four beds each, with some single and double rooms. A minimum of 50 beds in all. An examining room or surgery for examinations and treatments. Adequate provision for recreational and occupational therapy.

4. Professional staff:

   (a) An attending physician who visits the home twice a week, sees each patient at least once a week, is on call for emergencies and is notified at once regarding any unexpected changes in a patient's condition.

   (b) Registered nurses in the ratio of one to each 16 patients. One attendant.

   (c) A trained dietician.

   (d) A trained occupational therapist.

COMPARISON WITH GREAT BRITAIN

In comparison with Great Britain, organized convalescent care in the United States seems to have attained neither the same volume nor the same acceptance as an important, integral part of medical care. In 1930 there were in the United States 7.1 convalescent beds per 100,000 population distributed over 179 institutions, with approximately 60 per 100,000

needed, while Britain had 53.6 per 100,000 located in 343 institutions. The British convalescent homes are an outgrowth of need, beginning in the eighteenth century, and stem from three major factors: (1) a large part of the British population lived in overcrowded unsanitary housing in the 1700's and 1800's, necessitating their admission to hospitals when ill; (2) hospital expansion did not meet the continued demand for beds and it became necessary to discharge patients early, either to their own homes or, when these were unsuitable, to alternate places of care; and (3) the more recent demand by clinicians and public health officials for convalescent care as part of the preventive medicine program. Although Britain's housing has improved in the intervening years, its social consciousness has also grown and, more recently, standards of medical care have risen markedly. The demand for convalescent care has, therefore, continued. By the early 1930's the British trend was toward establishing government operated convalescent homes rather than increasing the number of homes under philanthropic and mutual assistance auspices, the sponsorships under which this service first developed.[10/]

These factors are being duplicated in this country, though belatedly. The overcrowded housing situation, among other factors, is causing many ill persons to seek admission to hospitals; the demand for hospital beds is necessitating early discharges, even in an era when new therapies and drugs are decreasing the average length of hospital stay; and the clinician's desire that his discharged patient receive maximum benefit from the intensive medical service provided during hospitalization is creating an appreciation of, and demand for, proper convalescent care. The analogy may go even further. Since the number of convalescent beds in this country falls far below need, since philanthropic funds are now less readily available and since, historically, we tend to meet widespread health and social welfare needs through public auspices, it seems likely that eventually we may provide convalescent care through government, especially for those unable to pay for service.

10/ Elizabeth G. Gardiner, Convalescent Care in Great Britain, Chicago, University of Chicago Press, 1935.

THE SITUATION IN NEW YORK CITY

The most current, authoritative information on convalescent homes in New York City, as distinguished from nursing homes, is reported in a study sponsored by several interested local groups and recently published by the Hospital Council of Greater New York.[11/] The following data are from this source.

The number of convalescent homes in New York City in 1930 represented almost half the total in the United States. However, even under such seemingly favorable circumstances, and in the absence of a study of needs, it is not certain that the number of beds in New York City are sufficient in volume or quality to meet the demand. From 1935 to 1944 the number of homes declined from 53 to 38, the number of beds from 3,443 to 2,567 and the beds per 100,000 population from 47.20 to 33.67. During this period the number of beds for adults and children in general convalescent homes decreased, while those for cardiac patients in special convalescent homes increased 76.6 per cent. Although all the reasons for closure of homes are not recorded, it is noted that many succumbed to war-wrought problems of operation. During approximately this same period the homes had a fairly constant average annual occupancy rate of about 80 per cent. In this connection, it is interesting that high occupancy rates were associated with the homes of larger size, those receiving public charges and those having resident or regularly visiting physicians.

Detailed data for both the convalescent homes and their patients were reported for 1940. All 46 homes were under church or non-sectarian auspices. Two-thirds of the aggregate 3,223 beds were in general and the remainder in special convalescent homes (cardiac, orthopedic, neurological). Moreover, almost three-fifths of all the beds were for children. As a group, the 46 homes provided

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11/ Elizabeth G. Gardiner and Francisca K. Thomas, The Road to Recovery from Illness, Hospital Council of Greater New York, 1945. (Sponsors of the study: Committee on Public Health Relations of the New York Academy of Medicine, New York City Department of Hospitals, Hospital Council of Greater New York, United Hospital Fund of New York, Welfare Council of New York City.)

944,436 days of care to 26,281 patients during the year. Although there were homes with less than 25 beds each and others with over 150 beds, the average capacity per home was approximately 72 beds.

From the fact that almost three-quarters of the patients were referred by general hospitals and another 10 per cent by social and health agencies, it seems evident that the value of organized convalescent care is rather widely recognized by such organizations. Analysis of the pay status of the patients in 1940 indicates that only one-fifth were wholly or partially financially self-sufficient.

	Per Cent Distribution	
Pay Status	Patients	Days of Care
Total	100.0	100.0
Full-pay	6.7	5.2
Part-pay	13.9	10.9
Public charges	28.9	45.6
Free	50.5	38.3

The cost of care of public charges was paid by official welfare and health agencies while that of free patients was met by endowment funds of the homes, contributions and monies from financial federations. The average stay per patient was two to three weeks for adults and a little under four weeks for children under care in general convalescent homes. Both free patients and those who paid their own way, in whole or in part, tended to stay a shorter period than those who were public charges. This may be related to the greater liberality of public welfare agencies and of funds available to them, or to the higher proportion of cardiac and orthopedic cases among the public charges, two types of cases staying for protracted periods.

THE SITUATION IN UPSTATE NEW YORK

In New York City it is possible to obtain data which distinguish between convalescent and nursing homes because of information continuously gathered by such organizations as the Hospital Council and United Hospital Fund. Unfortunately, similar information is not available for upstate New York as a whole. There is neither a national organization which appraises these facilities in the same way that the American Medical Association and the American College of Surgeons survey hospitals, nor is there official statewide licensure or inspection service applicable to all convalescent homes. They are most often confused with nursing homes, the same institution providing either both services or, more often, the latter only. However, the general impression exists, unsubstantiated by a study or survey, that there are relatively few bonafide convalescent homes in upstate New York.

Medical Domiciliary Care

CONVALESCENT VS. MEDICAL DOMICILIARY CARE

The foregoing discussion has dealt with convalescence to emphasize the need for proper care for those of the chronically ill who are capable of complete or partial recovery, or restoration to limited activity despite a physical handicap. However, others of the chronically ill, incapable of such recovery, become custodial cases. They must be cared for indefinitely either in their own homes or in medical domiciliary institutions designed for this purpose. The distinction between the convalescent, including the long-term convalescent, and the custodial care cases is not clearly defined today, nor are places for their care differentiated through clearly stated functions and admission policies. Except in a few large urban centers having a wide range of highly specialized facilities, both types of cases depend largely on public homes and so-called nursing homes for care. These accept patients (1) requiring a planned convalescence, (2) requiring temporary nursing care under general medical supervision, (3) needing nursing service for long periods and (4) requiring either custodial or terminal care. Unless such a home is of especially high quality,

it is not likely that each of these types of patients will receive the care their conditions demand. Moreover, senile patients having psychotic and cerebral arteriosclerotic impairments, as well as chronic alcoholics, are frequently found in both nursing homes and public homes. The result is a heterogeneous grouping of patients and a tendency to provide similar care for all, too often only the custodial type of care. The service provided is too frequently devoid of personalized attention based on sound medical recommendations designed to achieve successful physical and mental convalescence, restoration to earning power or, for custodial cases, a reasonably happy life.

POTENTIAL FACILITIES

It is evident that an adequate program for the care of the chronically ill requires two types of service between hospital and home -- convalescent and medical domiciliary. Whether such services will be provided in separate facilities or in different units of the same institution is a decision inherent in long range planning.

The convalescent institution can play an important role in achieving the greatest possible rehabilitation of chronically ill patients. However, there appears little prospect that any considerable number of such institutions will be established in upstate New York in the near future, especially in the less densely populated sections of the State. Therefore, in the absence of suitable convalescent homes in this area, the following possibilities exist: (1) Convalescent care might be part of the care provided in the long-term care wing of the general hospital; (2) it might be provided in a voluntary (non-profit) convalescent home established contiguous to and as a part of a voluntary general hospital; (3) it might be provided in a public "custodial" or "medical domiciliary" institution,

such as a county nursing home; (4) it might be provided in a proprietary nursing home; (5) it might be provided in the infirmary of a voluntary home for the aged; or (6) it might be provided in the patient's own home.

A wing of the general hospital caring for long-term patients is neither the ideal nor the most economical place for such care. A county nursing home, on the other hand, could provide such care for the chronically ill if its facilities and staff were adequate. However, in utilizing the county nursing home for this purpose, it should be stressed and reiterated that the case of each patient should be reviewed periodically to determine the possibility of his discharge, either to his own home or to some other more appropriate place of care. Ideally, institutional convalescent care should be given in institutions especially designed for the purpose. Since such care chronologically and medically follows that given in general hospitals, the most reasonable development would be that of institutions which would be, in effect, extensions of such hospitals.

Nursing Homes

For purposes of discussion, a nursing home is regarded as one providing shelter, board and nursing care and services under medical supervision to sick, infirm or handicapped persons not in need of hospitalization.

Many of the medically indigent chronically ill are cared for in nursing homes which also admit paying patients. Therefore, information on the homes caring for the indigent gives a general picture of the types of homes available to, and used by, a majority of the general population. Public welfare officials generally patronize neither the very poor quality nor the very expensive nursing homes, but the average homes.

STUDY MADE BY STATE DEPARTMENT OF SOCIAL WELFARE

In 1943, local departments of public welfare requested the New York State Department of Social Welfare to reimburse for care in nursing homes without first exacting "prior approval." The Department, to secure information as a basis for consideration of the proposal, gathered data on the situation by the sampling method.[12/]

Findings. Relatively few of the local departments of public welfare which had placed relief recipients in the 109 nursing homes studied had a clear conception of the relationship of nursing home care to medical care in general, or of the quality of service provided. The homes generally accepted the convalescent, the chronically ill, the aged and the infirm but, with scattered exceptions, excluded alcoholic, cancer, infectious disease and mental cases and post-operative patients requiring considerable care. Most of the homes had urban locations. Most presented fire hazards, were small (only one-third could accommodate 20 or more patients) and were operating at almost full capacity. Only one-half had been at their present locations for three years or longer. Although they were reported as having comfortable beds, adequate space between beds, sufficient bed clothing, suitably lighted rooms and necessary ventilation, a majority lacked the facilities and equipment requisite for proper care. The study did not attempt to evaluate the quantity or quality of the medical and nursing care provided, but did note that the homes were generally negligent in keeping records, that only one-third had registered nurses and that the remainder relied on either practical nurses or untrained personnel. The prevailing monthly rates were $25 to $45 in New York City and $40 to $65 in upstate New York.

12/ Reported in A Study of Nursing Homes in New York State, 1943, New York State Health Preparedness Commission, May 1946. (The basic data collected and tabulated by the State Department of Social Welfare were interpreted and published by the Commission, with the official approval of the Department.)

Half of the 1,362 patients under care in the homes studied were recipients of public assistance, 80 per cent of whom were 65 years old and over and most were women. Contrary to previous impressions, the relief recipients generally had not been placed in the nursing homes immediately following hospitalization. More than two-thirds were cardio-vascular, neurological, psychiatric, rheumatic, metabolic, glandular or vitamin deficiency cases; and an appreciable number showed evidence of some mental condition -- senility, forgetfulness, confusion, childishness. One-half had been placed in the respective nursing homes solely for medical and the remainder for social or medical-social reasons. The majority had been in the present homes less than one year.

Conclusions. One outstanding conclusion of the medical social workers and institutional inspectors making the study was that a patient may be perfectly satisfied and content in a nursing home entirely inadequate from every standpoint relating to minimum standards of care. This would indicate that the morale of individual patients, a vital factor in recovery, is probably closely related to the attitude of the proprietor and staff, the accessibility of the nursing home to the patient's friends and relatives, and the similarity of the nursing home to the patients' previous environment.

The homes studied differed widely in quality, were neither universally satisfactory nor unsatisfactory, but could not, as a group, be considered proper institutions for ill persons. The preponderance of aged persons under care, many with poor prognoses, indicated that the volume of convalescent care provided was negligible. Even under these circumstances the demand for beds exceeded supply. As a result, local welfare officials, obligated to place patients at rates their respective communities were willing and able to pay, could not be too selective in their choice of homes for placement.

From an administrative viewpoint, the nursing homes had received no appreciable leadership in integrating their service with those of the total public medical care program; and no well-defined policy of State reimbursement for

nursing home care had been established. The wide range of quality, the transitory nature of many locations and the extremely commercial attitude of some operators, had created reluctance to place increasing reliance on nursing homes as a medical resource, without simultaneously encouraging the establishment of alternate facilities for care of both the medically indigent and those patients able to pay for service.

Subsequent action. The State Department of Social Welfare reports[13] that the findings of the study resulted in the Department's (1) officially defining a nursing home for purposes of reimbursement (September 1944), thereby insuring State financial participation in the costs of care for the medically indigent in nursing homes; (2) establishing nursing home care as a medical item, reimbursable only when recommended by the attending physician; and (3) removing ceilings from rates reimbursable by the Department.[14]

Such reimbursement was made contingent upon the local department of public welfare certifying the nursing homes used; and, although minimum standards for this purpose were suggested, they were not mandatory. According to the State Department of Social Welfare, the process of certification (1) made it possible for the Department to establish a file of nursing homes used locally for recipients of public assistance (July 1945); (2) caused State and local public welfare officials to become more aware of the problems and cost involved in providing nursing home care; and (3) made State and local welfare officials conscious of the role of nursing homes in a medical program, and of the need for increasing their adequacy.

NUMBER OF HOMES IN 1945 AND 1946

From July 1945 to May 1, 1946, a period of ten months, the number of nursing homes certified for use by the local commissioners of public welfare rose from 400 homes with 5,110 beds to 447 homes with 6,139 beds, an increase of 12 per cent in the number of homes and 20 per cent in

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13/ In a letter from Commissioner Robert T. Lansdale, New York State Department of Social Welfare, to the New York State Health Preparedness Commission, May 17, 1946.

14/ New York State Department of Social Welfare, Reimbursable Care in A Private Nursing Home (Bulletin No. 105), September 19, 1944.

the number of beds. Since the 1945 data were assembled just before the end of World War II and the 1946 data eight months following cessation of hostilities, the rise indicates that the demand for nursing home beds is increasing and is not solely related to such war-wrought factors as family dislocations and shortages of nurses, physicians and hospital beds. Moreover, in October 1946, when 425 nursing homes were certified by local commissioners of public welfare, the Division of Vital Statistics, New York State Department of Health, had an additional 419 homes listed (exclusive of known tuberculosis cottages) wherein deaths from tuberculosis and cancer had occurred or from which cases of cancer and measles had been reported -- making an unduplicated total of 844 nursing homes. Undoubtedly there are many more homes in the State but their number is unknown as there is no all-inclusive roster thereof.

Additional data on nursing homes certified by the local commissioners (July 1945) are presented in Tables 2 and 3.[15/] Although less than a quarter of the nursing homes had accommodations for 20 or more patients each, their combined capacities accounted for more than half that of the entire group of homes. The prevailing rates in upstate New York were $60 and $90 and those in New York City $80 to $125 per month - - a sharp contrast to the 1943 findings showing rates of $40 to $65 upstate and $25 to $45 in New York City. State participation in the cost of care, with certification as a prerequisite, the general increasing awareness of the nursing home problem and demand for beds exceeding supply probably were factors in this rise. There was no definite correlation between the monthly rates of a home and its size. However, when large homes, which can spread overhead costs more widely, tend to have the same rates as small operations (under five beds), the question arises as to the quality of care in the latter.

15/ Data adapted from unpublished tabulations provided by the New York State Department of Social Welfare, 1945.

Table 2. Number and Bed Capacity of Nursing Homes Used by Local Departments of Public Welfare in New York State, July 1945.

Bed Capacity	Homes		Bed Capacity	
	Number	Per Cent Distribution	Number of Beds	Per Cent Distribution
Total	400[a]	100.0	5,110[b]	100.0
Under 5 beds	93	23.3	250	4.9
5-9 beds	109	27.2	755	14.8
10-19 "	109	27.2	1,442	28.2
20-34 "	71	17.8	1,712	33.5
35 beds and over	18	4.5	951	18.6

a/ Ten homes with 341 beds were in New York City and the remainder in upstate New York.
b/ Exclusive of the bed capacity not reported on one home.

Table 3. Number of Nursing Homes Used by Local Departments of Public Welfare in New York State, Exclusive of New York City, by Maximum Monthly Rate and Bed Capacity of Home, July 1945.

Maximum Monthly Rate	Total Homes	Number of Homes					
		Under 5 Beds	5-9 Beds	10-19 Beds	20-34 Beds	35 Beds & Over	No Report
Total	390	93	108	108	66	14	1
Under $50	41	8	16	10	5	2	-
$50-59	34	13	12	5	4	-	-
60-69	112	46	28	23	14	1	-
70-79	118	12	26	39	32	9	-
80-89	38	7	12	14	4	-	1
90-99	8	1	2	3	1	1	-
100-124	12	1	4	4	3	-	-
125-149	2	-	1	1	-	-	-
150-174	15	4	5	6	-	-	-
175 and over	9	-	2	3	3	1	-
Not reported	1	1	-	-	-	-	-

CONTROLS In addition to public opinion, there are several well known controls which, if properly administered, may be expected to promote and maintain safe, sanitary and adequately equipped nursing homes capable of providing a good quality of care. These controls are: (1) reimbursement for care of recipients of public assistance on the basis of established and enforced standards, (2) licensure of nursing homes, and (3) critical selection of homes by agencies using them.

Reimbursement for Care of Public Charges. Since some of the patients in many nursing homes are public charges, the quality of the service required by the official welfare agencies for their care may be effective in determining the quality of these homes. As the same home frequently admits both the medically indigent and those able to pay for care, the latter will benefit from the standards of care exacted for the former. However, when demand for nursing home beds exceeds supply, proprietors can choose their clientele and may reject relief recipients for whom they might be required to provide a high quality of service. Conversely, when bed supply exceeds demand, the same proprietors are anxious to admit relief recipients and are, therefore, more amenable to meeting the standards required. One should not lose sight of the fact that in periods when nursing homes welcome the medically indigent, cared for at public expense, the patients able to pay for care may be forced to patronize either the homes with rates considered too high by welfare officials or those not chosen by them because of the poor quality of care provided. Thus, although the practice of reimbursement is helpful, it does not uniformly raise the standards of all nursing homes.

As previously stated, the New York State Department of Social Welfare now reimburses for nursing home care without "prior approval," but has not required that mandatory criteria be applied by local departments of public welfare in certifying nursing homes. The responsibility for judging the nursing homes has been placed on local welfare officials, many of whom do not have staff personnel

competent to assume this assignment. Concurrently, the Department, as a policy, has neither assigned staff to make such inspections upon local request nor assisted the local units in developing properly qualified personnel for this service. There is, therefore, no uniformity among the homes used in the various localities and no consistent minimum standards of care. Consequently, the quality of care varies from community to community in relation to local social-mindedness, competency and financial ability. Although there is little doubt that State financial participation has improved the quality of nursing home care provided the medically indigent, it is equally true that mandatory, rather than suggested, criteria prerequisite for reimbursement, supplemented with leadership in establishing local inspection services of high quality, would ensure better results and the development of a competent factual basis for future planning.

Licensure. Nursing homes in states, counties or cities covered by licensure systems must, as a condition of operation, fulfill requirements specified in local ordinances, or state laws, and the regulations of the administering agency. Homes are usually licensed under one of three general methods: (1) licensure systems applying to nursing homes only, i.e., wherein this type of facility is defined and then required to meet the requirements set forth; (2) licensure of homes caring for the aged, which is tantamount to licensing nursing homes since such homes either care for some aged persons, among others, or wish to be permitted to do so; and (3) comprehensive licensure systems covering all types of institutions caring for ill persons. In the latter, each facility is classified as to type (general hospital, special hospital, maternity hospital, convalescent home, nursing home, etc.) and is then obligated to meet the requirements set forth for the particular classification assigned. Licensure may be applicable to a town, city, county or an entire state, depending upon the geographical jurisdiction of the body passing the enabling legislation.

In New York State licensure systems specific for nursing homes exist in Mt. Vernon, New Rochelle, New York, Syracuse, Yonkers and Nassau County, the local departments of health being the licensing agencies, except in New York City where the Department of Hospitals is responsible. In general, the nursing home operator must file an application; the home is inspected by the licensing agency, often in cooperation with the local fire, building and zoning authorities; and the license is granted if the prescribed conditions are met. The published requirements of these communities tend to emphasize safety and sanitation standards rather than those relating to the quality of medical and nursing care provided.[16/]

When licensure covers only a limited local area, homes can escape regulation by moving a short distance beyond the geographical jurisdictional line. When it is on a county basis, inspectional jurisdiction is divided between county and local officials, local (town, village, city) fire marshals and building inspectors passing on the fire safety and structural aspects of licensure and the county acting relative to the sanitation, nursing and medical aspects of care. This division of authority results in a wide variation of standards within a single county.[16/]

Although they do not have licensure systems, Buffalo and White Plains exercise a legal control over nursing homes through their respective lodging house ordinances. The Consolidated Health District of Saranac Lake and Harrietstown has regulations addressed to the standardization of sanatoria, especially those accepting tuberculosis cases. In Rochester, the registration of proprietary hospitals, sanatoria, nursing homes and convalescent homes is mandatory, subsequent inspection of these institutions is optional with the Commissioner of Safety and non-conformance to published regulations punishable.[16/]

16/ New York State Health Preparedness Commission, Regulation of Nursing Homes in New York State, Sept. 1946.

At least twenty states have laws licensing nursing homes.[17] The fact that such legislation was passed in 14 of these states within the last five years indicates that these facilities are exciting concern and a demand that they provide a quality of service concomitant with the public interest. In eight states the laws are comprehensive, covering virtually all institutions caring for ill persons.[18] The respective state departments of health are the licensing agencies in 12 states, and always where licensure is comprehensive; while the departments of welfare are responsible in seven states, including five wherein licensure is specifically directed to the protection of the aged.[19] This indicates a tendency to assign the supervision to the health unit when coverage is comprehensive or directed to nursing homes generally, and to the welfare unit when licensure is directed more specifically to the care of the aged.[20]

The usual procedure in licensing these institutions is that the operator files an application, the state licensing agency inspects the premises and, if the home meets the standards specified, grants a license. The state agency often solicits the cooperation of the official state and local health, welfare, fire, building and zoning authorities in making its determination, and frequently requires that homes submit for approval any plans for new construction or material remodeling. The requirements most commonly made cover construction, safety, sanitation (including food), accommodations, equipment, admission policies, records and reports; while those addressed to the quality of service provided are less frequent and usually less precise. In fact, a review of the enabling legislation, rules and regulations of the respective states lends credence to the impression that

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17/ California, Colorado, Connecticut, Delaware, Illinois, Indiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota and Texas.

18/ California, Colorado, Connecticut, Maine, Maryland, Minnesota, Oklahoma, South Dakota.

19/ In addition, the State Department of Institutions and Agencies is the licensing department in New Jersey.

20/ New York State Health Preparedness Commission, Licensure of Nursing Homes in Other States, Sept. 1946.

licensure in many instances is primarily concerned with the physical plant and sanitation, rather than the quality of care provided. There are exceptions. New Jersey maintains a continuing supervisory relationship with each nursing home, resulting in their progressive improvement[21]; North Dakota offers assistance in studying the need for new homes in any particular locality and advocates a co-operative, continuing consultant service to proprietors; and New Jersey and Missouri enforce specific requirements addressed to promoting continuing medical care to patients in nursing homes.[22]

Selection of Homes on Basis of Criteria. Organizations placing a number of individuals in nursing homes can, individually or collectively, establish their own criteria and select for their patients those homes meeting their specifications. This is true of such agencies as local public welfare departments, private family welfare agencies, home visiting nurse associations, social service departments of hospitals and similar agencies. From a realistic viewpoint, this method has the effect of boycotting homes not meeting requirements. When the supply of nursing home beds in a community exceeds demand, this method is effective; but when demand exceeds supply, nursing homes are not as dependent on such organizations for referrals and, consequently, are not as likely to strive to fulfill the criteria.

This unofficial method has been used in Monroe County, New York. In 1937 the County Department of Public Welfare wished to determine what constituted a "good" nursing home since it had to provide care for some aged and chronically ill persons who, although not needing hospitalization, could not be cared for properly in their own homes. Neither local licensure nor any similar local control of nursing homes existed; and no State agency inspected nursing homes or had suggested

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21/ Ibid. Also see Official Planning in Other States for the Care of the Chronically Ill, New York State Health Preparedness Commission, May 1946, p. 33.

22/ New York State Health Preparedness Commission, Licensure of Nursing Homes in Other States, Sept. 1946.

standards for them. Yet, because of general public demand, nursing homes were springing up "like mushrooms." Therefore, a local, voluntary committee[23] was formed to evaluate the problem, make suggestions and act as a unit. Minimum nursing home standards were formulated; a nurse was employed to inspect the homes used by the various participating agencies, with full approval of the proprietors; and the findings were considered by the committee. Subsequently the homes were classified as to type and quality, a register of acceptable homes for use of local agencies was established and subsequent inspections were made.[24] After two years the committee disbanded and the service became part of the program of the County Department of Public Welfare, which ultimately used this experience in officially establishing requirements for nursing homes wherein clients of the Department were placed.[25]

Although this method is effective, its benefits redound only to agencies and persons cooperating in using only those homes considered suitable, it is subject to the interaction of supply of and demand for beds, and it fails to safeguard the public as a whole.

THE CURRENT SITUATION

In discussing the nursing home situation with informed State and local official and non-official persons in the social welfare, public health, medical care and community organization fields, the following conclusions were reached: (1) Many of the nursing homes in the State are poorly housed, equipped and staffed and frequently provide a poor quality of care. (2) Many nursing homes are too small to assure adequate care at reasonable rates.

23/ With representation from the Monroe County and Rochester City Departments of Public Welfare, Rochester Public Health Nursing Association, Rochester Council of Social Agencies, New York State Department of Social Welfare, New York State Department of Health and a superintendent of a local nursing home.

24/ Stella M. Perryman, An Approach to the Private Nursing Home Problem in Monroe County, 1941. (Mimeographed).

25/ Monroe County Department of Public Welfare, "Nursing Home Care," Monroe County Medical Care Manual, 1941 (revised 1945).

(3) The demand for nursing home beds so far exceeds the supply that extremely low grade homes must too often be used and those of better quality can charge, and get, fees beyond the financial capacity of most persons. (4) There is a lack of continuity of medical service in many of the homes. (5) The services of most homes are not correlated with other local medical services and are not closely associated with general hospitals. (6) Little effort is made by the homes to rehabilitate the patients physically and mentally and thus enable them to resume more normal and productive lives in the community.

Local commissioners of public welfare, although specifically concerned with caring for the medically indigent, are close to local situations and are, therefore, in a position to report on them as they affect the total community. The following are quoted from a few of many replies received from such officials.

> "Our so-called nursing and convalescent homes are inadequate. They are understaffed and not properly equipped to provide extensive bedside care for chronic cases. They are willing to accept the infirm and homeless who require a minimum of care but those admitted are mostly ambulatory. In this sense they are but glorified boarding homes." 26/
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> --- From letter of Department of Public Welfare of Montgomery County, May 3, 1945, signed by Roland Hoffman, Commissioner.

> "In the City of Buffalo and the County of Erie, we have encountered considerable difficulty in finding nursing and convalescent homes for our welfare cases, due to the fact that private nursing and convalescent homes are receiving fees way beyond the amounts the County is allowed to pay. Private nursing homes in this vicinity are receiving $25 to $60 per week, whereas we are only allowed to pay from $50 to $60 per month."27/
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> --- From letter of Department of Social Welfare of Erie County, April 19, 1945, signed by Thomas W. H. Jeacock, Commissioner.

26/ New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill, May 1946, p. 11.

27/ Ibid., p. 11.

"The average nursing home gives care only in the daytime although a great many of the patients are just as much in need of nursing care at night. I have failed to find the nursing home which gives this kind of service. Furthermore, such homes have neither the equipment nor staff to give proper care. On the other hand, the county home is well equipped for 24-hour service seven days a week and also has the services of a licensed physician, as needed. Therefore, I am convinced that the problem must be solved by establishing public infirmaries to give the care and attention now needed and which, most assuredly, will be needed even more in the future." 28/

--- From letter of Department of Public Welfare of the Town of Union, April 6, 1945, signed by H. B. Osterhout, Commissioner.

"We are being called upon more and more by individuals from the community for advice and help in locating nursing homes for members of their families who are chronically ill, but for whom care at public expense is not needed. It is a problem to know how far this service should be developed when we realize that there are no over-all standards or supervision of nursing homes, and no control over the type of care offered by private nursing homes. We feel this service is implicit in our duties as a public welfare department, but we would, however, feel more confident in meeting this problem if there were a more effective means of licensing nursing homes, which would assure at least minimum standards of care and of equipment for meeting the needs of the patients." 29/

-- From letter of Department of Public Welfare of Westchester County, May 29, 1945, signed by Ruth Taylor, Commissioner.

On the whole, the nursing homes in New York State are lacking in quality, are not fulfilling their expected role in convalescent care, are tending to provide only a custodial type of service in caring for the chronically ill and are not a dynamic, integral part of the total medical service in the State. Conferences of the Commission staff with informed local persons have indicated that public sentiment favors eventual State regulation of nursing homes.

28/ Ibid., p. 17.

29/ Ibid., p. 19.

The existence of serious problems regarding nursing homes is further indicated by a recent statement of the Chairman of the Joint Hospital Board of New York State:

> "As a result of problems arising with the use of nursing homes by the State Department of Mental Hygiene, the nursing home problem was discussed at a meeting of the Joint Hospital Board on February 4, 1946. It was decided that the Departments of Mental Hygiene, Social Welfare and Health all have responsibilities in the area of nursing homes which can be met more satisfactorily by joint interdepartmental action. Consequently, the Board voted to proceed with consideration of the nursing home problem in the State." 30/

CONCLUSIONS AND SUGGESTED RECOMMENDATIONS

Regulation of standards and facilities of nursing homes is needed. It should apply to all nursing homes, and should be on the State level to obviate problems of jurisdictional boundaries between counties and within counties, and to insure a high quality of inspection service to communities financially or otherwise unable to provide such service. One of two methods suggest themselves: (1) comprehensive licensure of all institutions caring for ill persons, including nursing homes; or (2) regulation of nursing homes only. In this connection, one speculates as to the effect upon New York State if a number of adjacent states establish comprehensive licensure. Would this action tend to drive sub-standard facilities to New York State, if the latter lacked regulation?

Comprehensive licensure seems the desirable method for New York State to adopt as its long range objective in promoting a high quality of medical and nursing home care. However, if this method regulation were not established at an early date, it would seem advisable immediately to initiate some method of regulation addressed to nursing homes only; but this is clearly a second and alternate choice.

30/ From letter of Robert T. Lansdale, Chairman, Joint Hospital Board of New York State, to the New York State Health Preparedness Commission, May 17, 1946.

On the basis of the foregoing presentation the following principles are suggested in considering, formulating, establishing and administering statewide official regulation of nursing homes: 31/

1. Regulation should apply to all nursing homes, regardless of whether under proprietary, voluntary or public auspices.
2. When their facilities and staffs permit, local official agencies (county or city) should have the option of administering the regulatory process within their respective jurisdictions, under State formulated minimum standards.
3. Inspections relative to the sanitation, fire safety and structural standards should be made by the State or local official departments technically qualified and legally responsible for these aspects of the public safety. Preferably, such departments should assign proper personnel for this purpose to the enforcement agency.
4. Inspections of nursing homes should be made by a "team" of specialists, each member thereof to be qualified by training and experience to pass judgment on those aspects of regulation coming within his respective field of competency. The "team" should visit a nursing home as a group, its members should consult each other to insure consistency of conclusions and should submit a composite report.
5. Specific minimum standards should be formulated, published and distributed and should be applicable to each nursing home in the State. Such standards should include those relative to admissions and quality and continuity of medical and nursing care, as well as those relative to physical structure, fire safety, sanitation, accommodations, equipment and facilities.

31/ Previously published in Regulation of Nursing Homes in New York State, New York State Health Preparedness Commission, Sept. 1946.

6. Any method of regulation established should be legally capable of deterring the opening of any new nursing home which, on the basis of data and structural plans submitted by the potential operator (individual, association, church group, fraternal order or governmental unit), is adjudged incapable of meeting the established minimum standards of operation.
7. The State administrative agency should be just as responsible for teaching and assisting the nursing homes as for censuring them, i.e. in addition to formulating and enforcing standards it should offer constructive consultative and advisory service, upon request, to those nursing homes wishing to improve their operations.
8. The administrative responsibility should include the obligation to maintain records to insure a continuing basis of study of the nursing home situation and the regulatory process so that both might constantly be improved, on the basis of fact.
9. The nature of any regulatory process established should take cognizance of the manpower situation as it relates to the administrative staff, i.e. it should ensure complete coverage of nursing homes regarding details considered of fundamental importance and, instead of "spreading thin" on other aspects of regulation, should concentrate its efforts on those aspects most beneficial to the public interest.
10. Enforcement of regulations must be so executed as to preclude the closing of nursing homes when alternate facilities do not exist for placement of the patients who would thus be displaced.

In order to secure the maximum attainable benefit in setting and raising standards, allowing opportunity for teaching administrators of nursing homes and permitting public authorities to obtain current information, a system of registration, combined with the power to formulate and enforce regulations, would seem a suitable method for improving the quality of nursing homes in New York State,

particularly under currently prevailing circumstances. This would allow for the application of the preceding principles, would avoid the rigidity inherent in the traditional licensure system and would meet the objection that licensure would merely close down facilities which, though far from ideal, are better than nothing at all.

If licensure were the method of regulation chosen, the licensing agency would be legally obligated to inspect each nursing home probably annually or, less preferably, biennially. If qualified personnel were not readily available, the administering agency might have to "spread thin" its inspection service to reach each home, thus attenuating the quality of inspection of all homes. Registration would obviate such a legal responsibility.

The following are envisioned as the major characteristics of registration:[32/]

1. A certificate of registration would be required to be posted in every nursing home in the State as a condition of operation.
2. Certificates of registration would carry no expiration date and would be valid for an indefinite period, subject to revocation for cause.
3. On or before the effective date of registration, each nursing home in the State would be required to file with legally designated officials a completed official application for a certificate of registration, the administrative agency automatically approving all such applications.
4. Upon filing the completed application form, each such registrant (nursing home) would receive a copy of the minimum standards for operation of nursing homes, fulfillment of which would be requisite to continued operation.

32/ Ibid.

5. Subsequently, the administrative State agency would inspect those nursing homes in which inspection seemed most needed and, if necessary, could effect improvement through (a) offering advice and consultation; (b) placing the registrant on probation; (c) fine the offender, subject to appeal; or (d) revoke the certificate of registration, subject to appeal.

   (It should be noted that the administrative agency would not be obligated to inspect each nursing home at specified intervals, but could, if limitations of personnel require, deploy its manpower to inspect and advise those homes which, in the public interest, seemed to demand immediate attention. Others could be brought under purview as the situation demanded and/or the availability of qualified staff allowed.)

6. Each individual or group contemplating the establishment of a nursing home would be required, as a condition of opening, to file a completed, official application for a certificate of registration, accompanied by specified data, including structural plans. Approval of such applications by the enforcement agency would be based on a determination of the applicant's ability to meet the established minimum standards.

7. Plans for new construction or remodeling, the increasing of the bed capacity and the amendment of admission policies of any nursing home should be subject to approval of the enforcement agency.

The use of the registration method as a means of regulation could effectively fulfill the principles previously suggested. Although its staff probably would be unable to visit all nursing homes at the outset, the administrative agency gradually and systematically could achieve complete coverage, at the same time providing consultative and advisory service. It should dedicate itself to quality, not merely quantity, performance.

Supervised Boarding Homes

Closely related to the nursing home is the "supervised boarding home," a term occupying no niche in the social work, medical or public health glossaries. It has sprung up spontaneously and concurrently in a number of localities in New York State to describe a home approved by a local department of public welfare to provide shelter, board and personal services to sick, handicapped or infirm persons not in need of hospitalization or nursing home care, yet unable to resume normal living.

These homes have arisen because of bed shortages in general hospitals, the lack of beds and rising rates of nursing homes, an aging population and an increasing demand for care for ambulatory persons unable to care for themselves without assistance. A supervised boarding home is an approved boarding home whose proprietor is willing occasionally to assist the boarder with such services as dressing, combing the hair, tying shoes or serving a tray in bed. Professional nursing service is not needed and, when medical care is required, the boarder visits his physician's office or a clinic.

Some local departments of public welfare tend to use supervised boarding homes as a substitute for nursing homes. In practice, this frequently is a subterfuge for, if a home is classified as a supervised boarding home rather than as a nursing home, certification thereof is not a prerequisite for State reimbursement.

Although supervised boarding homes seem to have been developed to meet the immediate demand during wartime, evidence points to their continuance and increase, often encouraged by local departments of public welfare. They are an asset, providing a protected, homelike environment for ambulatory aged and/or ill persons who have no suitable homes of their own and who are neither sufficiently ill nor handicapped to require medical domiciliary, nursing home or hospital care. As the individual boarder's physical condition varies he may need nursing home care and, conversely, the nursing home patient may improve sufficiently to "graduate" to the supervised boarding home, thus setting up an interflow of individuals among various types of facilities meeting the needs of the moment.

The emerging importance of the supervised boarding home, its place in the gamut of facilities and the services it should provide are reported in a recent paper describing such homes in Monroe County.[33] In addition, the New York City Department of Public Welfare has made a study of such homes used by its clients as a basis for developing policies, standards and budgetary schedules relative to boarding home care.[34] These are but two examples expressing a trend -- the acceptance of boarding home care for handicapped individuals, mildly ill persons and the realization that demand therefor is increasing.

If these trends are prophetic, it may be incumbent upon the State to protect the aged and the ill in the selection of boarding homes, just as it now guards children in the choice of foster homes. The aged and ill, like children, often need protection, cannot speak for themselves too effectively and frequently are financially dependent upon government. Therefore, the State Department of Social Welfare might assume leadership in formulating minimum standards for those supervised boarding homes accommodating public charges whose care it wholly or partially reimburses. Moreover, this service might ultimately be extended to the non-dependent aged and ill. Local welfare units, under leadership from the State Department, might set up rosters of supervised boarding homes meeting the specified standards and make such registers available to the non-dependent, upon request.[35] Standards for such homes might be established and applied now in localities where there is no housing shortage, and to others as their respective housing situations improve.

33/ Jean V. Masters, Developing the Formulae for Suitable Housing for the Aged -- The Boarding Home. Presented at the New York State Conference on Social Work, Rochester, Nov. 1944.

34/ New York City Department of Public Welfare, Study of Boarding Homes, 1945.

35/ The Rhode Island State Department of Social Welfare maintains a file of licensed homes for aged or convalescent persons and existing vacancies which is available to qualified agencies placing clients. Placement service is also made available by the Department to physicians and individuals.

Public Homes

In discussing the public homes and their infirmaries, the New York State Health Preparedness Commission wishes only to present its concept as to the place of these institutions relative to care for the chronically ill. A more detailed analysis of these facilities will undoubtedly be made by the Subcommittee on Adult Institutional Care of the Special Committee on Social Welfare and Relief of the New York Joint Legislative Committee on Interstate Cooperation.

There are approximately 23,000 general hospital beds in upstate New York approved by the American Medical Association; over 6,000 beds in the upstate nursing homes certified by local commissioners of public welfare, only a part of which are used by public charges; and in 1944 there were 12,593 beds, including 3,002 infirmary beds, in the 60 upstate public homes.[36] This indicates the number of beds in the latter institutions as compared with those in the other two types of strictly medical or medically related facilities. In 1943 the upstate public homes cared for 14,318 persons, about one-third of whom were under 65 years of age, with almost three times as many men as women.

No detailed analysis of the physical condition of these patients has been made, no widespread attempt to classify them diagnostically has been initiated and there has been no concerted effort to ascertain the types of care required by them, on the basis of their individual physical condition and social situation. However, the findings of other states should give some indication as to what a detailed study in New York State might reveal. A study of public homes in Illinois, made in 1945 by the Illinois Public Aid Commission, indicated that four-fifths of the population of these homes was in need of continuous nursing service and medical care.[37]

36/ Based on data from Directory of Institutions for Adults, New York State Department of Social Welfare, 1943, and revisions for 1944.

37/ State of Illinois, Committee to Investigate Chronic Diseases Among Indigents, Interim Report to the Sixty-Fourth General Assembly, June 7, 1945, p. 9.

A similar study of county homes made in 1939 in Maryland, including medical and psychiatric examinations, revealed that 62.2 per cent of the inmates were chronically ill and required nursing and medical care, and that an additional 18.6 per cent required care in mental hospitals -- a total of 81.2 per cent of the public home population.[38/]

Data assembled by the Health Preparedness Commission on public charges known to the Nassau County Department of Public Welfare in 1944 indicate (1) that 71 per cent of the patients in the County Home were chronically ill and (2) that two-thirds of the days of care provided by the Home were to chronically ill patients. Of 235 persons studied who were served by the Home in 1944, 64.7 per cent suffered from some chronic illness, 20.4 per cent had an illness not classified as chronic and 14.9 per cent were undiagnosed and, presumably, were not ill.[39/]

Therefore, without knowing the exact proportion today in New York State, it might be assumed that its public homes likewise care for a high proportion of ill persons, most of them chronically ill.

Additional credibility is given to this assumption by a study made by the Health Preparedness Commission of first admission forms submitted to the State Department of Social Welfare by the public homes of upstate New York for 1938. This analysis showed that almost half the admissions (49.5 per cent) were for disability due to chronic illness or age, while an additional one-third (31.8 per cent) were necessitated because of need for temporary medical care -- a total of 81.3 per cent.[40/] See Table 4, page 44.

38/ Maryland Legislative Council, Research Division, Report on Almshouses in Maryland, April 1940.

39/ From data on medical and hospital care provided individuals under care of the Nassau County Department of Public Welfare, 1944. Collected by the Health Preparedness Commission in cooperation with the Department. To be published.

40/ New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, "Physical Condition of Persons Admitted to County Homes," Medical Care in New York State, 1939, Legislative Document (1940) No. 91, p. 184.

Table 4. Reasons for First Admissions to Public Homes, Distributed by Age, New York State, Exclusive of New York City, 1938. a/

Reason for Admission	Total		Distributed by Age b/		
	Number	Per Cent	Under 16 years	16 to 64 years	65 years and over
Total admissions	5,252	100.0	143	3,125	1,984
Prolonged residence for disability due to chronic illness or age	2,592	49.5	10	962	1,620
Temporary medical care	1,670	31.8	123	1,272	275
Temporary shelter	970	18.4	10	876	84
Not reported	20	0.3	-	15	5

a/ New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, "Physical Condition of Persons Admitted to [illegible] Homes, Medical Care in New York State, 1939, Legislative Document (1940) No. 91, p. 184.

b/ Per cent distribution, by age: total, 100.0%; under 16 years, 2.7%; 16 to 64 years, 59.5%; 65 years and over 37.8%.

ROLE OF THE PUBLIC HOME

Many of the chronically ill in the State are admitted to public homes either because of lack of alternate facilities for long-term care of those not needing hospitalization, or because the public homes may actually be providing the type of care needed. Whatever the reason, these homes today apparently are much used by such patients. Therefore, the question arises as to whether these institutions should continue this service, as part of a comprehensive program for care of the chronically ill, or whether alternate facilities should be established, leaving to the public homes the population not requiring institutionalization for medical or nursing care reasons.

Today the terms "custodial facility," "medical domiciliary institution" and "county home infirmary" are synonymous in the minds of many, with little differentiation between the role of public home infirmaries and nursing homes, except

that one is under public and the other under proprietary auspices. With the advent of more widespread public assistance, the individual dependent on government for food, shelter, fuel and clothing no longer must look to the public home as a source of shelter and board. Consequently, the public home population is changing from one of persons primarily seeking subsistence to one of individuals preferring congregate care and of physically and mentally disabled persons unable to care for themselves outside an institution. The "county home farm" in many localities has gradually become a vestigial remainder or an historic tradition, with the inmates often physically unable to perform farm labor chores. The county home, and of necessity its infirmary, is slowly changing its function, even if not consciously so. Its role is merging with that of the nursing home and, in some upstate communities, it is no longer confining its care to the indigent, but is admitting patients able to pay for service.

THE CURRENT SITUATION

As in the case of nursing homes, the Commission Staff has discussed and has had correspondence with informed State and local persons relative to public homes. These contacts reinforce the general impression that the public homes in upstate New York provide a wide range of quality of care, some having excellent standards, others providing only the most meager and dreary custodial care. In this connection, it should be noted that the public homes of Onondaga and Schenectady Counties and Poughkeepsie and New York Cities were registered by the American Medical Association in 1944 as "related institutions," and those of Delaware, Monroe and Suffolk Counties as hospitals [41/] -- a mark of medical approval. The Monroe County Home is also approved by the American College of Surgeons.

41/ American Medical Association, Journal of the American Medical Association (Hospital Number), Vol, 127, No. 13, March 31, 1945.

Recent replies from local commissioners of public welfare in the State indicate that 57 welfare districts lack adequate custodial care facilities and an even greater number suitable nursing and convalescent homes.[42/]

A number of persons with whom this subject has been discussed are convinced that: (1) Each public home which plans to admit or continue to house chronically ill persons should, in whole or in part, be converted into a cheerful, homelike nursing home of high quality under public auspices. (2) The converted homes should become community facilities and should admit those able to pay for care, as well as the indigent, especially since future admittees may be recipients of Old Age and Survivors Insurance benefits able to pay for at least part of their care. (3) The care of chronically ill public charges admitted to homes meeting minimum standards should be reimbursed by the State Department of Social Welfare under the same formulae applicable to reimbursement for care outside such institutions. (4) Every effort should be made to assist the public homes to throw off their social stigma and insure their acceptance as medically related institutions, just as State tuberculosis and mental hospitals are regarded. (5) The alcoholic, senile psychotic and cerebral arteriosclerotic cases should not continue to be part of the general population of the average public home, but should be provided with proper care either in special institutions or specifically designated sections of the larger public homes.

These are not new or untried conceptions. The Onondaga and Monroe County Home Infirmaries, and probably others, now admit paying patients. Illinois has translated this concept into practice for, after the recent conversion of some of its county homes into chronic care facilities, eligibility for admission has been

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42/ New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill, 1945, p. 8.

extended to include patients able to pay for care, and has attracted such patients.[43] Likewise, in Connecticut,[44] Maryland[45] and New Jersey[46] provision is made, or is imminent, for the admission of paying patients to public homes.

More specifically, since more adequate public facilities have been made available, Illinois has experienced an increased demand for care and has found it possible to transfer many relief recipients to the public assistance program. In fact, the demand has been of such volume that the admission of paying patients has been limited to ensure beds for those indigent needing care. This situation is described by the Director of the Illinois Public Aid Commission, as follows:

> "In all thirteen counties where homes are now approved under the chronic care program, it has been necessary to establish admission quotas as between assistance cases and private pay patients and to discontinue the original plan of accepting patients from outside the respective counties. In all of these counties intake has had to be limited according to beds available and to nursing staff available. As a result, as maximum capacity is approached, the waiting list for private pay patients becomes larger in proportion to assistance cases applying for entrance. Far from becoming a "dumping gound" the volume of applications for care has restricted intake and stimulated efforts to match quality and extent of care to the needs of the individual patients admitted. One county has just reported a disturbingly large waiting list of private-pay patient applications for admission because this limitation of intake is necessary."[47]

43/ Laws of the State of Illinois, Sixty-Fourth General Assembly, 1945, Senate Bill No. 212 (approved June 13, 1945) and Senate Bill No. 213 (approved June 6, 1945.)

44/ General Statutes of the State of Connecticut, 1945 Supplement, Chap. 147, Sec. 611 h - 615 h.

45/ Annotated Code of Maryland, 1943 Supplement, Art. 43, Sec. 526-530.

46/ State of New Jersey Laws of 1940, Chap. 119 (supplementing the "1924 Poor Law"); Laws of 1939, Chap. 263, and Laws of 1946, Chap. 175 (supplementing the "1931 County Referendum Law").

47/ From letter of Mr. Raymond M. Hilliard, Director, Illinois Public Aid Commission, to the New York State Health Preparedness Commission, December 4, 1946.

Local commissioners of public welfare in New York State, themselves responsible for operating public homes, have expressed the following opinions:

> "It would seem to me, considering the State as a whole, that something should be done in the postwar period to provide suitable and sufficiently large county infirmaries in every county in the State so that the infirmary would be in a position to admit chronic cases which are unable to purchase adequate service and care elsewhere. There are many instances where chronic cases are financially able to pay the cost of their care in a county infirmary, but are financially unable to purchase care from an entirely private source, or unable to make arrangements to receive proper care in hospitals or nursing homes," 48/
>
> -- From letter of Department of Social Welfare of Wayne County, April 21, 1945, signed by Elmer G. Butts, Commissioner.

> "There is a great and growing need for providing efficient care for the aged and chronically ill at a reasonable cost, for those ineligible for public assistance are anxious to retain their independence as long as possible with their limited resources. We receive many inquiries from relatives able to pay the amount it costs for care at the County Infirmary, yet who are not financially able to undertake an indefinite obligation of $15 to $25 weekly. County Infirmary care is, of course, unavailable to such private patients. The only answer that occurs to us is a convalescent hospital or institution, partially publicly sponsored and supported, where such cases might be cared for efficiently. This should not be regarded as a public assistance project, any more than a farm subsidy, or public provision for a public health problem. We believe such an institution could give much more satisfactory and efficient care than can private homes, where it is almost impossible to guarantee required standards and conditions and where prohibitive prices for this type of care always prevail." 49/
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> -- From letter of Department of Public Welfare of Cortland County, May 7, 1945, signed by Frank W. Chrisman, Commissioner.

> "We also have a great many calls for patients who are chronically ill and whose means are limited. They can and are willing to pay for their relatives oftentimes, if their current earnings are sufficient to pay the charge at the Infirmary, as they cannot manage on hospital or the regular nursing home rates. I feel, as time goes on, we are going to be confronted more with this type of case, which means that public funds will undoubtedly have to be provided to make facilities available to care for this type of case." 50/
>
> -- From letter of Department of Welfare of Niagara County, May 4, 1945, signed by Milton E. Switzer, Commissioner.

48/ New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill, 1945, p. 15.

49/ Ibid., page 17.

50/ Ibid., page 12.

"At the present time we have patients in our Infirmary and have also received many applications from patients in the City who are able to pay their way in the Infirmary. Many patients who have been in the hospital ready to be discharged have applied to our Department for admission to the Infirmary. They have no one to care for them at home as the heads of their families are employed, and they are not able to get anyone to come into the homes to look after the patients. If we had a nursing home, these patients could be cared for in the nursing home and it would relieve the congestion in the Infirmary; or, if our Infirmary were enlarged, and the stigma of the City Home removed, it would, undoubtedly, solve our problem on nursing care." 51/

-- From letter of Department of Public Welfare of the City of Newburgh, May 2, 1945, signed by T. J. Cannon, Director.

CONCLUSIONS

A choice eventually must be made. Shall the public homes serve only as places of congregate care for those who, although physically and mentally able, prefer institutional care? Shall the homes be devoted exclusively to caring for the chronically ill not needing hospitalization? Or shall they care for both types of cases, so often progressively interchangeable, simultaneously? This question is partially answered by a number of concurrent circumstances. The public homes are established, built. They already have a large number of the chronically ill under care. Facilities are needed immediately. Limitations of materials and manpower will probably delay any contemplated extensive construction. Therefore, if the public homes plan to admit or continue to house the chronically ill, it seems logical, economical and sound that, whenever structure and location are suitable, the existing homes or a portion of each should be converted to provide medical domiciliary care of high quality under public auspices. If they are thus converted, they would be community facilities, not solely institutions for the indigent, and should be made available to all the population, regardless of economic status. As in the case of other community medically related facilities, patients able to pay for care should do so, with the local departments of public welfare paying for the medically indgient.

51/ Ibid., page 13.

In suggesting means of transforming the public homes into suitable institutitons because they plan to care for those chronically ill not requiring hospitalization, it is not necessary to evaluate the homes as they are today. But it does seem important to indicate the major factors inherent in effecting their conversion into adequate facilities. Under existing legislation there are three principal avenues of control: (1) the State Department of Social Welfare now is responsible for approving new construction, expansion and material remodeling of such homes [52]; (2) the Department now has the power to inspect and make recommendations relative to their operation [53]; and (3) the New York State Postwar Public Works Planning Commission has the power to approve or disapprove applications for State capital funds for such facilities. Current trends indicate the possibility of two other means of control in the near future: (1) If the State should reimburse for care of the medically indigent in public homes, it could prescribe the conditions under which reimbursed care should be provided. (2) If comprehensive State licensure of all institutions caring for ill persons were initated, the requirements thereunder for institutions caring for the chronically ill would be applicable to the public homes accepting such patients.

Moreover, it seems timely now to consider the trend that our capital expansion should take. Fourteen counties are currently planning new construction, expansion or material remodeling of their respective public homes. The aggregate estimated construction cost for the projects in ten of these counties is $2,677,730. For the slightly different ten counties whose eventual planned capacities are known, there will be a rise from 1,497 beds to 2,038 beds, an increase of 36 per cent. Most of these projects have already been approved by the State Department of Social Welfare and by the State Postwar Public Works Planning Commission. See Table 5, page 51.

52/ Social Welfare Law of New York State, Annotated, Sec. 202.

53/ Ibid., Sec. 201, 203.

Table 5. Counties Submitting Plans for New Construction or Material Remodeling of Their Public Homes to the New York State Department of Social Welfare, As of October 24, 1946. a/

County	Description of Project	Total Capacity of Home (inc. Infirmary)		Approval of Preliminary Plans		Estimated Construction Cost
		Present	Planned	By State Dept. of Social Welfare	By State Postwar Public Works Planning Commission	
Broome	Renovation of men's building, recreation room. New serving pantry.	320	350			No report
Cattaraugus	New infirmary, women's building, employees' wing, residence for commissioner, residence for farmer	157	300	X	X	$326,771
Chemung	New men's building. New central heating plant under consideration	170	190	X	X	$300,000
Chenango	New men's building. New central heating plant under consideration	125	165	X		No report
Cortland	Complete new plant	85	NR	Pending	X	$292,900
Essex	Considering additions and alterations	62	130	Tentative	X	$125,000
Livingston	Complete new plant	90	156	X	X	$378,956
Niagara	New infirmary wing. New central heating plant under consideration	350	419	Tentative	X	$231,132
Otsego	In process of planning extensive additions	125	NR			No report
Sullivan	Complete new plant at new site	60	100	Tentative	X	$308,660
Tompkins	New infirmary at site apart from county home	52	NR	Pending	X	$185,324
Ulster	In process of planning additions	100	140		X	$ 75,000
Washington	Small addition	145	NR	X		No report
Wyoming	Complete new plant	63	88	X	X	$148,000

NR - "no report"

a/ Data adapted from information supplied the Health Preparedness Commission by the New York State Department of Social Welfare in a letter of October 24, 1946; except that information on estimated construction costs are those reported in Approved State and Municipal Projects, New York State Postwar Public Works Planning Commission, September 1, 1946.

Regulation relative to such homes desiring conversion might be made applicable (1) at the time of construction or remodeling and (2) during the period of operation. Future construction should be realistically conceived by meeting current and potential needs rather than by following any traditional pattern. State agencies exercising controls over new construction or remodeling could formulate criteria prerequisite to approval, including proof of the ability of the sponsoring agency to operate the contemplated facility properly. Such standards might include requirements of a medical care nature, of which the following are illustrative:

1. Approval should be based upon the results of a survey, for each community contemplating construction, of the local medical and medically related facilities, their capacities and relationship to each other.
2. Consideration should be given to the use of existing, little used, yet appropriate, capital structures in lieu of new construction. (For example: The conversion of a wing of a general hospital having low occupancy. The conversion of one or all of several well-constructed units of a multi-unit local tuberculosis hospital having a decreasing patient population).
3. Consideration should be given to the question as to whether or not the county (or city) which will operate the institution is sufficiently populous to justify the capital expenditure. If not sufficiently populous, service might be bought from an adjacent county or city.
4. A careful analysis should be made as to whether or not the future program of the institution should incorporate a farm operation. (Today fewer and fewer inmates are physically capable of performing agricultural labor chores.)
5. Whenever possible the institution should be located close to the greatest concentration of population of the county, preferably near an approved general hospital. (Location is a factor in the availability of personnel, accessibility to the services of a general hospital and the willingness of patients to patronize the facility.)

6. The structure, or a part thereof, should be conceived as an allied medical institution and should be planned functionally to serve this purpose efficiently and economically.

7. The institution should be so planned and placed on the terrain as to allow for future structural expansion by the addition of wings or additional floors in conformity with the basic architectural pattern.

8. Any plan submitted for approval should provide space for recreational, occupational therapy and rehabilitative activities of the inmates, i.e., assembly room (auditorium), chapel, workshops, etc.

9. The immediate contemplated capacity of the structure should take into consideration (a) the population of its predecessor, (b) the waiting list, (c) the desirability of admitting individuals now inappropriately under care in proprietary nursing homes, general hospitals or their own homes and (d) the estimated increase in numbers in the near future of age groups and types of medical cases eligible for care.

10. Approval of the plans submitted should be contingent upon the willingness of the sponsoring authorities to admit full-pay and part-pay patients who fulfill the economic, social and medical conditions of eligibility.

11. The sponsoring authorities should present a statement of the anticipated needed numbers and qualifications of various types of personnel required to operate the institution; and the approving authorities should determine whether the professional and non-professional personnel complement and their qualifications are such as to provide the high quality of service required.

12. The sponsoring authorities should present a detailed budget on anticipated annual gross and net operating costs and per diem costs per inmate, preferably by type of service to be provided, i.e. nursing care, medical domiciliary care, shelter care, etc.

Standards of operation might well embrace those relative to safety, fire protection, sanitation, facilities, equipment, accommodations, furnishings, administration, personnel, admission and discharge, nursing service, medical service, records and reports. Since the diversity of competence required to evaluate the institutions on the basis of these criteria exceeds that of any one individual, with rare exceptions, it is advisable that the determinations be made by an experienced and qualified "team" of individuals who, as a group, possess these abilities.

The following exemplify a few of the standards, of a medical nature, which might profitably be required to insure proper operation:

1. The institution, or at least a part thereof, should be regarded as an allied medical institution, occupying the same place in the community for the type of service it provides as an approved general hospital enjoys for its appropriate type of service.
2. It should be eligible for registration as at least a "related institution" by the American Medical Association, i.e., conforming to the requirements for such registration.
3. The individuality of patients should be preserved by offering (a) either single rooms or ward units not exceeding a capacity of four, (b) a variation among the rooms as to color of paint on the walls, and (c) dining tables of small capacities, not exceeding six.
4. The following types of patients should be eligible for care, regardless of economic status:
   (a) Convalescent patients for whom an organized, planned, institutional regime is medically indicated and those requiring less planned care, but whose homes are unable to provide the type care needed.

(b) Bedridden cases requiring medical domiciliary care, but not hospitalization, and for whom this type of care cannot be provided in the patient's own home.

(c) Ambulant and semi-ambulant cases not requiring hospitalization who cannot be suitably placed in supervised boarding homes and whose own homes are undesirable.

5. The institution should admit such full-pay and part-pay patients, in addition to the medically indigent, as may request admission.

6. The medical staff of the institution should be chosen in the same manner which is customary among the approved local general hospitals, i.e., open service, closed service, rotating service, etc.

7. The medical staff of the institution should be organized into a medical committee under a salaried medical administrator serving either on a full-time or part-time basis.

8. No institution should provide the active type of medical service which is commonly regarded as the province of the general hospital, but each should formulate a working agreement with one or more of the local registered general hospitals[54/], and preferably with one also approved by the American College of Surgeons.

9. The decision to transfer a patient from the institution to a general hospital, or vice versa, should be made only on recommendation of a physician.

10. The ratio of registered and practical nurses and attendants to the patient population should conform to a specified minimum.

11. Each institution should have an organized program of rehabilitation and occupational therapy so graded that the patient can progress from one type of activity to another.

54/ Registered by the American Medical Association as a hospital.

12. Each institution should review, at stated intervals, and on a medical-social casework basis, the potentiality for discharge of each patient or his transfer to an institution providing a type of care more appropriate to his condition.

Voluntary Homes for the Aged

As in the case of public homes, the Subcommittee on Adult Institutional Care of the Special Committee on Social Welfare and Relief of the New York State Joint Legislative Committee on Interstate Cooperation will undoubtedly report detailed data, conclusions and recommendations on voluntary homes for the aged. Mention thereof is made here only to call the attention of the reader to the fact that these institutions now are playing an increasingly important role in the care of the chronically ill between hospital and home. Furthermore, their contribution might be augmented, to the mutual benefit of themselves and the community.

The New York State Department of Social Welfare exercises supervisory responsibility relative to 200 voluntary homes for the aged whose aggregate capacities in upstate New York approximate those of the public homes for that area.[55/] This indicates the extent of such facilities, many of which number chronically ill persons among their populations.

Frequently established and maintained by fraternal, church or nationality organizations, homes for the aged generally have well-known and publicized admission policies. Up to now many have restricted application to members of the sponsoring organization and, traditionally, many have accepted for care only persons in good health at the time of admission. This latter prohibition has not been wholly effective as persons in "good health" are likely to become ill shortly after

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55/ New York State Department of Social Welfare, Social Welfare Services in New York State, Albany, May 1946, p. 3.

admission, while others, rejected for relatively mild physical defects, remain ambulant and active for years. The advent of the Old Age Assistance and Old Age and Survivors Insurance programs have made possible the subsistence of many old persons outside institutions, thereby influencing the size of the institutional populations and waiting lists.

Since many of these homes accept responsibility for guests who become ill following admission, they should be encouraged and assisted to provide proper, adequate and continuous medical and nursing service for such patients. Also, a liberalized admission policy might tend to stabilize the financial condition of some homes for the aged for two reasons: (1) the homes, now often populated by persons admitted on a life basis,[56/] might be better able to attract recipients of public assistance; and (2) might similarly attract the beneficiaries of Old Age and Survivors Insurance benefits. Therefore, and especially in the light of community needs, these institutions might be encouraged to adapt a greater part of their facilities and programs to the care of persons known to be chronically ill at the time of admission. If the physical structure of the homes could be converted, their admission policies liberalized and their programs modified to meet this need, the resulting service to the respective communities would be enhanced; and chronically ill persons of similar religious, fraternal or nationality backgrounds could more readily and happily be placed in institutions of their choice.

56/ The practice whereby a lump sum is paid upon admission to defray the cost of care of the admittee for life. Since such fees are often admittedly below the aggregate cost of care per individual, the differential must be met by philanthropic funds, a diminishing source of income.

Conclusions

Nursing homes, supervised boarding homes, county and city public homes and voluntary homes for the aged are adaptable, potential resources for providing care between hospital and home to the chronically ill who, although not requiring hospitalization, cannot receive suitable long-term or convalescent care in their own homes. If properly conceived (or converted), staffed and operated, these three types of institutions could provide an invaluable, psychologically sound, much needed service more economically than can purely medical institutions; while the supervised boarding home of high quality could supplement the medical domiciliary type of service. The demand for service is so great that a place exists for all these facilities, in addition to others; but their continued existence may well depend on their ability to adapt to community needs and to conform to minimum standards of performance.

Although some of these facilities provide adequate care today, others must be altered physically and encouraged to provide a better quality of service. To this end the following suggestions, previously discussed in more detail, are reiterated for consideration:

1. All facilities of the nursing home type should be made subject to State regulation, preferably through inclusion under a comprehensive licensure system covering all institutions caring for ill persons. However, if such licensure is not advisable or attainable at an early date, registration of nursing homes should be established immediately.
2. The State Department of Social Welfare, in cooperation with local departments of public welfare, might assume leadership in formulating standards for those supervised boarding homes which accommodate public charges; and might ultimately make available to the non-indgient a register of such approved homes.

3. Each public home which plans to accept chronically ill persons for care might be converted, in whole or in part, into an institution capable of adequately caring for those chronically ill who, although not needing hospitalization, cannot be cared for properly in their own homes or in supervised boarding homes. It should become a general community facility, admitting those able to pay for care as well as the indigent; and should be developed as an integral part of the gamut of local medical services. In addition, State reimbursement should be made available for the care of chronically ill public charges placed in public homes meeting minimum prescribed standards.

   The standards of construction and operation of such converted public homes could be achieved by (1) the enforcement of criteria of construction prerequisite to State approval for building new facilities, or remodeling existing structures; and (2) the establishment and application of State regulations relative to standards of maintenance and operation.

4. Voluntary homes for the aged should be encouraged to liberalize their admission policies and to adapt a greater part of their facilities and programs to the proper care of chronically ill persons.